

**ESRD DEATH NOTIFICATION**  
**END STAGE RENAL DISEASE MEDICAL INFORMATION SYSTEM**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0448. The time required to complete this information collection is estimated to average 17 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, Mailstop N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

1. PATIENT'S LAST NAME		FIRST	MI	2. HEALTH INSURANCE CLAIM NUMBER	
3. PATIENT'S SEX a. <input type="checkbox"/> Male b. <input type="checkbox"/> Female		4. PATIENT'S STATE OF RESIDENCE		5. DATE OF BIRTH <div>    <div>    </div>    <div>    </div>    <div>    </div> MONTH DAY YEAR</div>	
				6. DATE OF DEATH <div>    <div>    </div>    <div>    </div>    <div>    </div> MONTH DAY YEAR</div>	
7. PROVIDER NAME AND ADDRESS (CITY AND STATE)					
8. PROVIDER NUMBER		9. PLACE OF DEATH (Check one) a. <input type="checkbox"/> Hospital b. <input type="checkbox"/> Dialysis c. <input type="checkbox"/> Home d. <input type="checkbox"/> Other		10. WAS AN AUTOPSY PERFORMED? a. <input type="checkbox"/> Yes b. <input type="checkbox"/> No	
11. CAUSES OF DEATH (Enter code form List of Causes below.)					
a. Primary Cause <div>    </div>		b. Were there Secondary Causes? <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify		(1) <div>    </div>	(3) <div>    </div>
				(2) <div>    </div>	(4) <div>    </div>

**LIST OF CAUSES****CARDIAC**

- 23 Myocardial infarction, acute
- 24 Hyperkalemia
- 25 Pericarditis, incl. cardiac tamponade
- 26 Atherosclerotic heart disease
- 27 Cardiomyopathy
- 28 Cardiac arrhythmia
- 29 Cardiac arrest, cause unknown
- 30 Valvular heart disease
- 31 Pulmonary edema due to exogenous fluid

**VASCULAR**

- 35 Pulmonary embolus
- 36 Cerebrovascular accident including intracranial hemorrhage
- 37 Ischemic brain damage/Anoxic encephalopathy
- 38 Hemorrhage from transplant site
- 39 Hemorrhage from vascular access
- 40 Hemorrhage from dialysis circuit
- 41 Hemorrhage from ruptured vascular aneurysm
- 42 Hemorrhage from surgery (not 38, 39 or 41)
- 43 Other hemorrhage (not Codes 38-42, 72)
- 44 Mesenteric infarction/ischemic bowel

**INFECTION**

- 49 Septicemia, due to vascular access
- 50 Septicemia, due to peritonitis
- 51 Septicemia, due to peripheral vascular disease, gangrene
- 52 Septicemia, other
- 53 Pulmonary infection (bacterial)
- 54 Pulmonary infection (fungal)
- 55 Pulmonary infection (other)
- 56 Viral Infection, CMV
- 57 Viral Infection, Other (not 64 or 65)
- 58 Tuberculosis
- 59 A.I.D.S.
- 60 Infections, other

**LIVER DISEASE**

- 64 Hepatitis B
- 65 Other viral hepatitis
- 66 Liver-drug toxicity
- 67 Cirrhosis
- 68 Polycystic liver disease
- 69 Liver failure, cause unknown other

**GASTRO-INTESTINAL (see also 50)**

- 72 Gastro-intestinal hemorrhage
- 73 Pancreatitis
- 74 Fungal peritonitis
- 75 Perforation of peptic ulcer
- 76 Perforation of bowel (not 75)

**OTHER**

- 80 Bone marrow depression
- 81 Cachexia
- 82 Malignant disease, patient ever on immunosuppressive therapy
- 83 Malignant disease (not 82)
- 84 Dementia, incl. dialysis dementia, Alzheimer's
- 85 Seizures
- 86 Diabetic coma, hyperglycemia, hypoglycemia
- 87 Chronic obstructive lung disease (COPD)
- 88 Complications of surgery
- 89 Air embolism
- 90 Accident related to treatment
- 91 Accident unrelated to treatment
- 92 Suicide
- 93 Drug overdose (street drugs)
- 94 Drug overdose (not 92 or 93)
- 98 Other identified cause of death, please specify:

99 Unknown

12. FOR ALL DEATHS INDICATE YES/NO Renal replacement therapy discontinued prior to death: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, check one of the following: a. <input type="checkbox"/> Following HD and/or PD access failure d. <input type="checkbox"/> Following acute medical complication b. <input type="checkbox"/> Following transplant failure e. <input type="checkbox"/> Other c. <input type="checkbox"/> Following chronic failure to thrive		13. IF DECEASED RECEIVED A TRANSPLANT a. Date of most recent transplant <div>    <div>    </div>    <div>    </div>    <div>    </div> MONTH DAY YEAR</div> b. Was kidney functioning (patient not on dialysis) at time of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown c. Did transplant patient resume chronic maintenance dialysis prior to death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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14. REMARKS

15. NAME OF PHYSICIAN	16. SIGNATURE OF PERSON COMPLETING THIS FORM	DATE
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